Culturally and Linguistically Appropriate Services (CLAS) Standards for MDCH COC-Funded Agencies

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Michigan Department of Community Health
Division of Health, Wellness and Disease Control
HIV/AIDS Prevention and Intervention Section
Continuum of Care

Michigan CLAS Standards:
Ensuring Culturally and Linguistically Appropriate Services

Background
The original CLAS standards (National Standards for Culturally and Linguistically Appropriate Services in Health Care) were developed by the Office of Minority Health (OMH) within the U.S. Department of Health and Human Services (HHS). They were developed between 1997 and 2000, and published in final form in the *Federal Register* on December 22, 2000, as "recommended national standards for adoption or adaptation by stakeholder organizations and agencies."*

The CLAS standards were developed primarily for health care organizations, but can be used by other providers, including HIV/AIDS service providers, with very, very minor revisions. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

These standards have been adapted to say "service providers" instead of "health care organizations."

Culturally Competent Care (Standards 1-3)
[Note: These standards are considered *guidelines*, recommended by OMH for adoption as mandates by accrediting agencies.]

Revised Standard 1
Service providers should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2
Service providers should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area. For nonprofit organizations, this includes a diverse Board of Directors.

Standard 3
Service providers should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

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* The final report describing the standards and the process used to develop them is *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report.* Washington, DC: Office of Minority Health, U.S. Department of Health and Human Services, March 2001. Available on-line at http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf.

Language Access Services (Standards 4-7)

[Note: These standards are *requirements* for all recipients of federal funds.]

Standard 4

Service providers must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5

Service providers must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6

Service providers must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7

Service providers must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Organizational Supports for Cultural Competence (Standards 8-14)

[Note: Standards 8-13 are *guidelines,* recommended by OMH for adoption as mandates by accrediting agencies. Standard 14 is a *recommendation,* suggested by OMH for voluntary adoption by health care organizations.]

Standard 8

Service providers should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9

Service providers should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcome-based evaluations.

Standard 10

Service providers should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, provided to the Michigan Department of Community Health as part of their reporting, and periodically updated.

Standard 11

Service providers should ensure that staff at all levels have access to and are familiar with the

HIV/AIDS epi profile and needs assessment data, in order to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the HIV/AIDS population in the service area.

Standard 12
Service providers should develop participatory, collaborative partnerships with community-based organizations and communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13
Service providers should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14
Service providers are encouraged to regularly make available to the public information about their progress and successful innovations in implementing these standards and to provide public notice in their communities about the availability of this information.

Other Frameworks for Measuring Cultural Competence

In addition to the CLAS standards, there is another framework for cultural competence that is used by the Bureau of Primary Care, Health Resources and Services Administration and is consistent with CLAS. This framework focuses heavily on practices, and related measures are often useful in assessing a provider's success in meeting CLAS standards.

Seven Domains of Cultural Competence: In "Cultural Competence: A Journey," the Bureau of Primary Health Care identifies the following seven components of cultural competence—the areas organizations need to address in building cultural competence:*

1. Values and attitudes [Relates to CLAS standards #1 and #2]
2. Communications styles [Relates to CLAS standard #1 and #2]
3. Community/consumer participation [Relates to CLAS standards #11, #12, #14]
4. Physical environment, materials, resources [Relates to CLAS standards #1 and #7]
5. Policies and procedures [Relates to CLAS standards #4-7, #8, #9, #10, #13]
6. Population-based clinical practice [Relates to CLAS standards #1, #8]
7. Training and professional development [Relates to CLAS standard #3]

- See "Cultural Competence: A Journey," on the Bureau of Primary Health Care website: www.bphc.hrsa.gov

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Sample Measures of Cultural Competence for Service Providers and their Relation to CLAS Standards

CLAS Standard	Sample Measures
Standard #1: Culturally Competent Care Service providers should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.	1. Provider displays, in common areas and in staff rooms, pictures, posters, artwork, and other décor that reflect the cultures and ethnic backgrounds of clients served by the provider. 2. Provider ensures that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of individuals and families served by the provider. 3. When using videos, films or other media resources for health education, treatment or other interventions, provider ensures that they reflect the cultures and ethnic background of individuals and families served by the provider. 4. Provider staff avoid imposing values which may conflict or be inconsistent with those of cultures or ethnic groups other than their own. 5. Supervisory staff screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with individuals and families served by the provider. 6. Provider policies require – and staff indicate awareness and compliance with policies – that both supervisors and all other personnel intervene in an appropriate manner when they observe staff or clients within the program or agency engaging in behaviors which show cultural insensitivity, racial biases, and prejudice. 7. Provider staff demonstrate that they recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture. 8. Provider staff demonstrate that they understand and accept that family is defined differently by different cultures (e.g., extended family members, fictive kin, godparents). 9. Provider staff demonstrate that they accept and respect that male-female roles may vary significantly among different cultures and ethic groups (e.g., who makes major decisions for the family). 10. Provider staff demonstrate understanding that the perception of health, wellness, mental health, and preventive health services have different meanings to different cultural or ethnic groups. 11. Provider staff demonstrate an understanding that grief and bereavement are influenced by culture.

CLAS Standard	Sample Measures
	12. Provider staff are well versed in the most current and proven practices, treatments and interventions for HIV/AIDS and related health, mental health, and/or social services problems among ethnically and racially diverse groups served.
Standard #2: Diverse Staff and Leadership Service providers should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area. For nonprofit organizations, this includes a diverse Board of Directors.	13. Provider staff reflect the client population they serve; staff at all levels are racially and ethnically diverse, and this is especially true of staff who interact with clients.
Standard #3: Education and Training Service providers should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.	14. Provider has in place regular (at least twice yearly) and appropriate professional development and training to enhance staff knowledge and skills in the provision of services and supports to culturally, ethnically, racially and linguistically diverse groups. 15. Provider ensures that staff are familiar with – and receive periodic updates or training on – the socio-economic and environmental risk factors that contribute to the major HIV/AIDS-related problems of culturally, ethnically and racially diverse populations served. 16. Before visiting or providing services in a home setting, provider staff receive training and resources for seeking information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally and ethnically diverse groups served by the provider. 17. Provider keeps abreast of the major health concerns and issues for ethnically and racially diverse client populations that may affect HIV/AIDS care, and provides regular information updates and/or training to staff regarding these issues.
Required Standards #4 – #7: Language Access Services **Standard #4: S**ervice providers must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.	18. Provider posts signs in the key languages of the target populations. 19. Provider staff who first interact with clients have a "language card" for use in determining a new client's language. 20. Provider ensures that printed information disseminated by the agency or program takes into account the native language and average literacy levels of individuals and families receiving services. 21. When interacting with individuals and families who have limited English proficiency, provider staff demonstrate recognition that:

CLAS Standard	Sample Measures
Standard #5: Service providers must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.	* limitations in English proficiency are in no way a reflection of their level of intellectual functioning. * their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin. * clients may or may not be literate in their language of origin or English. 22. Provider uses bilingual-bicultural staff and/or personnel and volunteers skilled or certified in the provision of medical, mental health, social work, or other relevant specialized interpretation during treatment, interventions, meetings or other events for individuals and families who need or prefer this level of assistance. 23. For individuals and families who speak languages or dialects other than English, provider ensures that staff attempt to learn and use key words in their language so that they are better able to communicate with them during assessment, treatment, or other interventions. 24. Provider uses family members for interpretation only on request of the client. 25. Provider attempts to determine and communicate to service staff any familial colloquialisms used by individuals or families that may affect assessment, treatment, or other interventions. 26. Whenever possible (depending on the level of use of the language involved), provider provides notices and communiqués to individuals and families in their language of origin. 27. Provider staff understand that it may be necessary to use alternatives to written communications for some individuals and families, as word of mouth may be a preferred method of receiving information.
Standard #6: Service providers must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).	
Standard #7: Service providers must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.	
Standard #8: Service providers should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.	28. Provider's written strategic plan includes specific and measurable goals and strategies/plans for ensuring culturally and linguistically appropriate services. 29. Management responsibilities for accountability and oversight of CLAS goals and progress are clearly defined and regularly implemented. 30. Provider Board and staff review of strategic plan progress consistently includes review of progress towards CLAS goals.

CLAS Standard	Sample Measures
Standard #9: Self-Assessments Service providers should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.	31. Provider periodically (at least every three years) reviews the program's or agency's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural and linguistic competence. 32. Client satisfaction surveys consistently include questions related to CLAS performance. 33. Provider's Quality Management plan includes specific review of CLAS performance. 34. Provider's performance evaluation measures include CLAS-related objectives and measures.
Standard #10: Service providers should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, provided to the Michigan Department of Community Health as part of their reporting, and periodically updated.	35. Provider's intake form and client-level database include provision for recording the individual consumer's race, ethnicity, and spoken and written language skills and preferences. 36. Information about the consumer's race, ethnicity, and spoken and written language skills and preferences is obtained from all clients and recorded in client folders and data systems. 37. Provider provides aggregate data on client race, ethnicity, and language as part of its data reports to the Michigan Department of Community Health.
Standard #11: Service providers should ensure that staff at all levels have access to and are familiar with the HIV/AIDS epi profile and needs assessment data, in order to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the HIV/AIDS population in the service area.	38. Provider has access to and familiarity with the State demographic and epi profile, county or other regional data, and the Part B needs assessment. 39. Provider maintains information on the racial, ethnic, and language characteristics of people in their service area, and of people with HIV/AIDS in their service area.
Standard #12: Community and Consumer Involvement Service providers should develop participatory, collaborative partnerships with community-based organizations and communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.	40. Supervisory staff ensure that the provider seeks information from individuals, families, or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups served by the provider. 41. Provider consults with Part B community members from their area regarding CLAS issues.
Standard #13: Service providers should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.	43. Provider has a written client bill of rights, and makes it available in the major languages of its clients. 44. Provider has a written client grievance procedure that allows for complaints or grievances based on CLAS-related issues, provides information about the process in the major languages of its clients, and has an individual designated to assist clients who wish to file a grievance related to CLAS issues.

CLAS Standard	Sample Measures
Standard #14: Service providers are encouraged to regularly make available to the public information about their progress and successful innovations in implementing these standards and to provide public notice in their communities about the availability of this information.	45. Provider submits written updates on CLAS-related activities, progress, and challenges to the Michigan Department of Community Health, and makes written information available to the public at least annually.